Government of the District of Columbia

2003 D-2440 SUB
Disability Income Exclusion

032400210000

OFFICIAL USE ONLY

NAME AS SHOWN ON FORM D-40 AAAAAAAAAAAAAAAAAA YOUR SOCIAL SECURITY NUMBER 999-99-9999

Personal information

Date of your birth (MMDDYY)	Date you retired (MMDDYY)	Name of your employer	Payor, if other than employer
MMDDYY	MMDDYY	AAAAAAAAAAAAAAAAAAA	AAAAAAAAAAAAAAAAAAA

Date of spouse's birth (MMDDYY)	Date spouse retired (MMDDYY)	Name of spouse's employer	Payor, if other than employer
MMDDYY	MMDDYY	AAAAAAAAAAAAAAAAAAA	AAAAAAAAAAAAAAAAAAA

Have you filed a physician's certification for this disability in previous years? **X** YES **X** NO

If ***yes***, you do not have to file another certification. If ***no***, you must file the physician's certification below.

Income

If married, use both columns. Round cents to the nearest dollar. If amount is zero, leave the line blank.

		You	Your spouse
1	Total amount of disability payments received in 2003.	1 $ 999999999.00	$ 999999999.00
2	Multiply $100 by the number of weeks you claimed disability payments in 2003. If you received pay for part of a week, see instructions.	2 $ 999999999.00	$ 999999999.00
3	Enter line 1 or 2, whichever is less.	3 $ 999999999.00	$ 999999999.00
			Total Income
4	*Add the amounts for you and your spouse from line 3.*	4	$ 999999999.00

Limitation on exclusion

5	Federal adjusted gross income *Form D-40, line 12.*	5	$ 999999999.00
6	Taxable social security income *Form D-40 instructions, Calculation A, line d.*	6	$ 999999999.00
7	Subtract line 6 from line 5.	7	$ 999999999.00
8	Amount used to reduce disability income	8	- $15,000.00
9	Subtract line 8 from line 7. If zero or negative number, make no entry, stop here.	9	$ 999999999.00
10	Disability income exclusion *Subtract line 9 from line 4. Enter in calculation A, line e. (Form D-40 instructions)*	10	$ 999999999.00

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2003 Physician's Certification of Permanent and Total Disability

Name of disabled AAAAAAAAAAAAAAAAAA Social security number 999-99-9999

I certify that the above taxpayer was permanently and totally disabled on the date the taxpayer retired MMDDYY

Physician's first name, middle initial, last name

AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Physician's address (number and street) Suite/apartment number

99999AAAAAAAAAAAAAAAAAA 99AAA

City State Zip

AAAAAAAAAAAAAAAAAAA AA 99999-9999

Physician's phone number Physician's Sigtanure Date

999 999-9999

ATTACH THIS FORM TO YOUR FORM D-40.

Rev 11/03